ARNOLD PALMER HOSPITAL
For Children
Supported by Arnold Palmer Medical Center Foundation

LINE UP PATIENT I.D. LABEL HERE

PEDIATRIC REHABILITATION • CASE HISTORY FORM

DEMOGRAPHIC INFORMATION

Child's Name:_____ DOB:_____/_____/_____
Parent's/Guardian's Name: _____ Phone ( ) _____ (home)
Who is the child's primary caregiver?_____ ( ) _____(cell)
Address:_____ ( ) _____(work)
City, State, Zip:_____ Physician's Name: _____
Briefly describe your child's difficulties:_____
Language(s) spoken in the home: _____
Has your child had a previous evaluation?
❑ Speech/Language ❑ P.T. ❑ O.T. ❑ No When_____/Where?_____
❑ Hearing ❑ No When_____/Where?_____
❑ Vision ❑ No When_____/Where?_____
Does your child attend school/preschool/day care? ❑ Yes ❑ No
Where?_____ How often?_____

List family members living in home with child:

Name	age	relationship to child	occupation/grade	speech, language, hearing, or medical problems

BIRTH HISTORY

Health of mother during pregnancy:_____
Length of pregnancy: _____ Birth Weight: _____ Apgar Score: _____
Check any of the following which apply:
❑ Breech birth ❑ Trouble breathing ❑ Incubator used ❑ Unusual color at birth
❑ Dry birth ❑ Cesarean section ❑ Heart problems ❑ Feeding problems: ❑ Breast ❑ Bottle
❑ Forceps/Vacuum extraction used ❑ Drugs used during L&D/other:_____
❑ Alcohol/Drug used during pregnancy _____
❑ Length of stay in hospital? _____

MEDICAL HISTORY

Has your child or a member of the household had a recent exposure to any of the following?
❑ No ❑ Chicken Pox ❑ Measles ❑ Mumps ❑ Other:_____ Date of exposure:_____
Does your child or a member of the household have MRSA/VRE?
❑ No ❑ Yes If yes, who?_____
Does the child, any member of the household or anyone who frequently visits the household have T.B.?
❑ No ❑ Yes If yes, who? _____
Does the child 12 years old or greater (excluding Cystic Fibrosis patients) or any member of the household or anyone who frequently visits the household have a cough that has lasted longer than 2 weeks?
❑ No ❑ Yes If yes, who?_____
Check any of the following that your child may have had or has problems with:
❑ swallowing or choking ❑ lost consciousness ❑ frequent colds, sore throats, or earaches
❑ eyes ❑ serious accidents ❑ serious illness ❑ high fevers
❑ tonsils or adenoids ❑ seizures and convulsions ❑ surgical operations ❑ hospitalizations
❑ other:_____
Please explain all checked above: _____
_____
Specialists seen: _____
Current medications:_____
Allergies: _____

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SOCIAL/BEHAVIORAL HISTORY

Would child separate easily from parent for therapy? ❑ Yes ❑ No
Is your child a "picky" eater? ❑ Yes ❑ No
Check any of the following that describes the behavior of your child:
❑ Temper tantrums ❑ Withdrawn ❑ Plays well with others ❑ Short attention span ❑ Shy
❑ Prefers to play alone ❑ Overly active ❑ Frequently mouths objects ❑ Aggressive with playmates
❑ Sensitive to textures (e.g., clothing, glue)_____
Is there any history of or current sexual, emotional, or physical abuse? ❑ Yes ❑ No ❑ History ❑ Current
Is there any history of or current domestic violence? ❑ Yes ❑ No ❑ History ❑ Current

DEVELOPMENTAL HISTORY

Give approximate age at which child first did the following:
Toilet trained: _____ Fed self with spoon: _____ Sat alone: _____ Crawled: _____ months
Stood alone: _____ Walked alone: _____ months
Does your child fall frequently? ❑ Yes ❑ No
Does your child show a hand preference? ❑ Left ❑ Right ❑ None

SPEECH/LANGUAGE DEVELOPMENT

Was your child responsive as an infant? (Smile and cry appropriately) ❑ Yes ❑ No
Did your child make sounds/babble as an infant? ❑ Yes ❑ No
Does your child look at you when you're talking? ❑ Yes ❑ No When you're playing together? ❑ Yes ❑ No
When did your child first begin to use single words? _____ months
When did your child first begin to put two words together? _____ months
How many words are in your child's longest utterance? _____
How does your child usually let you know what he/she wants?

❑ Cries ❑ Uses a few words ❑ Points to what he/she wants
❑ Says many words, but only one word at a time ❑ Makes a few sounds
❑ Uses gestures (e.g., "Give it to me") ❑ Makes many different sounds
❑ Says two or three word sentences or simple phrasing ❑ Uses long sentences

At what time were you first concerned about your child's speech, language, or hearing problem?_____
_____
Approximately how much of your child's speech do you understand? ❑ less than 25% ❑ 25% ❑ 50% ❑ 75% ❑ 100%
Does your child seem aware of his/her problem? ❑ Yes ❑ No
My child can be understood by: parent ❑ Yes ❑ No strangers ❑ Yes ❑ No
How much of what you say does your child understand? _____
❑ few words only ❑ simple directions ❑ most of what you say ❑ almost all of what you say

SUGGESTIONS

Why are you visiting us today:_____
_____
_____
How do you help your child with his/her speech and/or motor difficulties?_____
_____
_____
I would like my child to learn how to: (Rank from most important to least important.)
1. _____
2. _____
3. _____

_____ Date: _____ Time: _____
Signature of parent or legal guardian

INTERPRETER ONLY

(Please Print)
Name: _____ Agency: _____
Telephone:_____ Language: _____

Copies of reports or additional sheets of comments may be attached to this form.